This is your application for New Hampshire Healthy Kids Medical Insurance or Medical Coverage for Pregnant Women.

***New Hampshire Healthy Kids Medical Insurance*** can provide health and dental insurance coverage for children who are under age 19. Some families may have co-payments and/or a monthly premium.

***Medical Coverage for Pregnant Women*** is a program that provides a full range of services, including prenatal, labor and delivery, and postpartum care, to pregnant women of any age. It also includes dental care services for those under age 21. There is no cost for this coverage.

## GENERAL INFORMATION ABOUT THIS APPLICATION

- ✓ **PLEASE READ EVERYTHING CAREFULLY AND FOLLOW ALL INSTRUCTIONS!** Please do your best to answer all the questions on this application. Do not answer any questions that you do not understand. If you need help with any part of this application, call toll-free 1-877-4NH-CHIP (1-877-464-2447). TDD Access: Relay NH, 1-800-735-2964.
- ✓ When you have finished filling out this application, sign, date, and mail it, along with copies of the proofs needed, to New Hampshire Healthy Kids, 25 Hall Street, Suite 303, Concord, NH 03301. **Don't forget to attach copies of required proofs!** If you are applying at an outreach site, they can mail it for you.
- ✓ When we receive your signed application, **with required proofs attached**, we will review it carefully. Someone will contact you if more information is needed. Once all necessary information has been received, we will make a decision on your eligibility. You will receive a written notice of our decision within 45 days of the day we receive your application. Some health care providers can determine pregnant women and children eligible on the spot. This is called "presumptive eligibility." The provider will tell you if you qualify for this quick eligibility. You will still need to show us all required proofs within 45 days or this eligibility will end.
- ✓ We are interested in knowing your Family's Primary Language (what language is used in the home, such as English, Spanish, or Turkish), and the Race (such as White, African-American, or Asian), and/or Ethnic Origin (such as Bosnian, Cambodian, or Italian) of each adult and child who is applying for medical coverage. **Sharing this information is strictly voluntary. Choosing not to tell us will not affect anyone's eligibility for medical coverage.**

## SOCIAL SECURITY NUMBERS AND CITIZENSHIP: WHAT YOU HAVE TO TELL US

- ✓ According to Section 1137 of the Social Security Act, we are required to ask for the Social Security Numbers (SSN) of all pregnant women, and some children, who want to receive medical coverage. If you don't want to or can't tell us the SSN of someone who wants this coverage, we will tell you if a number is required in order for that person to get medical coverage. **Not giving us the SSN of someone who does not want coverage, or of someone who does want this coverage but refuses to give us a SSN, will not affect the eligibility of anyone else in your family.**
- ✓ We are required to ask about the US citizenship or immigration status of every child or pregnant woman who wants to receive medical coverage. Pregnant women and some children must also provide proof of their citizenship or immigration status. Adults who don't want medical coverage for themselves do not have to tell us their status. Adults will have to tell us about their income if they are the parent of a child or are married to and living with a pregnant woman who wants medical coverage. Applying for Healthy Kids or Medical Coverage for Pregnant Women will not affect your immigration status.

## YOU HAVE THE RIGHT:

- ✓ **To not be discriminated against** because of race, age, color, creed, sex, national origin, marital status, disability, or political belief. If you believe we have discriminated against you, contact the Controller, New Hampshire Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301, or telephone (603) 271-6941 or 1-800-852-3345, extension 6941. TDD Access: Relay NH, 1-800-735-2964. There can be no retaliation against you for having made this contact.
- ✓ **To ask for an Administrative Appeals Hearing** if you are not satisfied with any decision made by the Department of Health and Human Services or the New Hampshire Healthy Kids Corporation. You can bring an attorney to the hearing, but you will have to pay any costs for this yourself. You can request a hearing either verbally or in writing by contacting a DHHS District Office, New Hampshire Healthy Kids, or the Office of Administrative Appeals, State Office Park South, 105 Pleasant St., Concord, NH 03301. Telephone: (603) 271-4292 or 1-800-852-3345, extension 4292; TDD Access Relay: 1-800-735-2964.

**PLEASE TURN THE PAGE – IMPORTANT INFORMATION IS ON THE BACK!**

# ✓CHECKLIST OF REQUIRED PROOF

You must provide certain proof so we can verify eligibility for those persons seeking medical coverage. Use this page to check for all the proofs you need to give us. **Not providing all the proof we need may cause a decision on your or your children's eligibility to be delayed or your application denied!**

## Proof of Family Income

Please send **ONE proof of income** for each income source listed below that is received by:

- Children who are applying for coverage,
- Parents who live with those children,
- Pregnant women applying for coverage, **and**
- A pregnant woman's husband, if living with her.

***Salaried or Hourly Employees***

- ☐ Copies of pay stubs for the last 4 weeks, **or**
- ☐ A letter from the employer on company letterhead stating hours worked and gross wages earned.

***Self-Employed Individuals***

- ☐ Most recent federal income tax form and all supporting schedules, e.g, Schedules C or E, **or**
- ☐ Other records, such as a recent Profit and Loss Statement.

***Other Kinds of Income***

- ☐ Documents detailing all income earned from rent, royalties, boarders, etc.
- ☐ Copy of any letter, bank statement, or check stub received by you, your child, or the other parent that tells the amount of any benefits received, such as Social Security, Unemployment, VA, Workers' Compensation, etc.

***Child Support Received***

We will accept what you say on this application as proof of the amount of child support received by your child from an absent parent. However, we reserve the right to request additional documentation to verify the child support income your child receives. **We will let you know if we need this. You do not need to send anything now**.

## Proof of Children's Age

Send a copy of any **ONE** of the following for **EACH** child requesting this coverage:

- ☐ Birth or baptismal certificate,
- ☐ School records with date of birth,
- ☐ Report card with date of birth,
- ☐ Doctor's statement or immunization record, **or**
- ☐ Hospital birth record.

## Proof of New Hampshire Residence

Send a copy of any **ONE** of the following that shows your current street address:

- ☐ Lease, rental agreement, or rent receipt,
- ☐ Electric, cable, heating fuel or telephone bill,
- ☐ Property tax bill, **or**
- ☐ Motor vehicle registration.

**You do not need a permanent address to qualify for this coverage! Call 1-877-464-2447 for help with proving NH residency.**

## Proof of Expenses You Want to Claim

When we calculate your income eligibility, we will deduct a portion of some kinds of expenses from your gross income.

***Child or Adult Care Expenses***

We will accept what you say on this application as proof of your child or adult care expenses. However, we reserve the right to request additional proof of these costs. **We will let you know if we need this. You do not need to send anything now.**

***Court-Ordered Child or Spousal Support***

You can deduct the amount you are ordered by a court to pay to a child or spouse. Send **ONE** copy of:

- ☐ The court order signed by a court official, **or**
- ☐ A letter from the court or your attorney confirming that you have a support order and for how much.

***Legal Wage Garnishments***

We will accept what you say on this application as proof of any legal wage garnishment deductions. However, we reserve the right to request additional documentation to verify these costs. **We will let you know if we need this. You do not need to send anything now.**

## Proof of Pregnancy

If you are applying for this coverage because you are pregnant, we need a signed statement or medical form from a licensed physician, registered nurse practitioner, or other licensed medical practitioner indicating that you are pregnant, the expected delivery date, and the number of babies you are carrying.

## Proof of Health Insurance

**If any child or pregnant woman who is applying for coverage has current insurance or has been insured in the past six months, please provide:**

- ☐ Copy of current insurance card,
- ☐ Notice of termination of the coverage, **or**
- ☐ Any official document from the insurance carrier showing the policy number, who the policy holder is, who is covered, and for what time period.

## Proof of Citizenship or Immigration Status

Send a copy of any **ONE** of the following for **EACH** pregnant woman or non-citizen applicant. We will tell you if you need to show proof of your child's citizenship.

- ☐ U.S. birth certificate or hospital birth record,
- ☐ U.S. voter registration card,
- ☐ U.S. passport,
- ☐ Alien Registration Receipt Card (Form I-551),
- ☐ Arrival/Departure Record (Form I-94), **or**
- ☐ Other official document from INS clearly stating citizenship, naturalization, or immigration status.

**PLEASE DO NOT SEND ORIGINAL DOCUMENTS. SEND COPIES ONLY!**

If you have trouble giving us any information, call our toll-free help number, 1-877-464-2447, or your local DHHS District Office. Or call 1-800-852-3345 and ask to be connected to the District Office serving your city or town. TDD Access: Relay NH, 1-800-735-2964.

# Application for NH Healthy Kids Medical Insurance or Medical Coverage for Pregnant Women

## 1. Please tell us who you are and where you live.

| Name (First, Middle Initial, Last) | Mailing Address (Only if Different from Street Address) | |
|---|---|---|
| Street Address (House/Apt. #, Street, City, State, Zip Code) | Daytime Telephone | Home Telephone |
| Family's Primary Language (Voluntary) | Have you ever used a different name or names? If so, please list: | |

## 2. Please tell us about the children living with you who are under the age of 19.

| Name (First, MI, Last) | Sex | Social Security Number (only if applying for medical coverage) | Date of Birth (mm/dd/yy) | US Citizen? (only if applying for medical coverage) | | If no, INS status? | Race/Ethnic Origin (voluntary) | Presumptive Elig. Date (Pres. Elig. Providers Only) |
|---|---|---|---|---|---|---|---|---|
| 1. | | | | Y | N | | | |
| 2. | | | | Y | N | | | |
| 3. | | | | Y | N | | | |
| 4. | | | | Y | N | | | |

Are there any children with special health care needs who require on-going support to remain in the home? ☐ Yes ☐ No

## 3. Please tell us about the parents of the children, and/or his or her spouse, who live in your household.

| Name (First, MI, Last) | Date of Birth (mm/dd/yy) | Race/Ethnic Origin (voluntary) | Relationship to: Child 1 | Child 2 | Child 3 | Child 4 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

Is anyone listed above pregnant? ☐ Yes ☐ No

Is this person applying for medical coverage today? ☐ Yes ☐ No

**If applying**: Her SSN:_____ Is she a US Citizen? ☐ Yes ☐ No

**If applying but not a US citizen**, her INS Status:

**Presumptive Elig. Date (Pres. Elig. Providers Only):**

_____/_____/_____

## 4. Please tell us about health insurance you or your children have now, or had in the last 6 months:

| Covered Individual | Insurance Company | Policy/Group Number | Policy Holder | End Date of Coverage |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## 5. Please tell us how much income your family has. Be sure to list all family income.

**A. Enter total pay from working BEFORE any deductions – NOT take home pay. Enter zero ("0") if you are unemployed.**

| Your income from working | Other parent/spouse's income from working (if living with you) |
|---|---|
| Employer Name and Telephone Number: | Employer Name and Telephone Number: |
| Income before deductions each pay period: $ | Income before deductions each pay period: $ |
| I get paid: ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly | They get paid: ☐ Weekly ☐ Every 2 weeks ☐ Twice monthly |
| ☐ Monthly Average hours worked each pay period: | ☐ Monthly Average hours worked each pay period: |

Are either you or the other parent/spouse self-employed? ☐ No ☐ Yes

If yes, estimate your average monthly income, after business expenses, from self-employment: $_____

| B. Other Income | Amount | Who gets this income? | How often is this income received? |
|---|---|---|---|
| Child support | $ | | |
| Alimony | $ | | |
| Social Security Disability (SSDI) | $ | | |
| Other Social Security payment | $ | | |
| Unemployment benefits | $ | | |
| Other (specify): | $ | | |

**PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS PAGE**

**6. Do you pay someone to take care of your children, or to take care of an adult in your household who needs care, while you are working? ☐ No ☐ Yes If Yes, tell us how much you pay for the care:**

| Name of child/adult in care | Age | Full Time | Part Time | Monthly out-of-pocket costs |
|---|---|---|---|---|
| | | ☐ | ☐ | $ |
| | | ☐ | ☐ | $ |
| | | ☐ | ☐ | $ |
| | | ☐ | ☐ | $ |

**7. If you have any of the following expenses, tell us how much you are ordered to pay every month:**

☐ Court-Ordered Child support: $ _____ ☐ Court-Ordered Spousal Support: $ _____ ☐ Wage garnishment (only if actually paid): $ _____

**8. Pregnant women and some children may qualify for help with unpaid medical bills for services received up to 90 days before the date of this application. If you want to apply for this coverage, you must meet all eligibility requirements for medical coverage and provide the required proof (see ✓CHECKLIST OF REQUIRED PROOF). Do you want to apply for this past coverage now? ☐ No ☐ Yes**

**9. Please tell us how you heard about Medical Coverage for Children or Pregnant Women:**

☐ Media (radio TV newspaper) ☐ School ☐ Health care provider ☐ District Office ☐ Friend/Family

**Circle one**

**10. Please read the statements below and sign at the bottom.**

By signing my name below, I agree to each of the following statements:

- All of the information I have provided on this application is true to the best of my knowledge. I understand and agree to give proof of my statements. I understand and agree that the Department of Health and Human Services (DHHS) may need to contact other persons or organizations to get necessary proofs of my eligibility. No additional permission is needed to get these proofs or other information.
- If I deliberately give any false information or withhold information related to my receipt of medical coverage, now or in the future, I may lose medical coverage and may be subject to other legal consequences.
- I understand that if my children are applying for Healthy Kids-Gold or I am applying for Medical Coverage for Pregnant Women, I must assign to DHHS the right to all third party medical payments, including medical support payments, and may have to reimburse DHHS for medical payments made that are later covered by a third party.
- Receipt of medical coverage for me or my children means that DHHS must be able to obtain medical records from providers if necessary, and I authorize my family's medical providers to release any medical records to the DHHS.
- I understand that if my children are applying for Healthy Kids-Gold or I am applying for Medical Coverage for Pregnant Women, we must disclose our Social Security Number(s).
- My signature below certifies that the individuals who are applying for assistance and who I have stated are US citizens, is a true statement. I understand that I may have to verify the individuals' citizenship status. I also understand that DHHS will not ask INS about the immigration status of anyone who is not applying for medical coverage.
- I understand that my eligibility for this coverage must be reviewed at least once a year, and at that time I will be sent a new application form to be completed and returned. I also understand that at that time I may be asked to provide new or additional proof of my income and other information I write on my review application, and that if I fail to give this proof on time my coverage could end.
- I understand I must report any changes in my household income within 10 calendar days of the change.

**Signature of Applicant/Representative** _____ **Date** _____

**OUTREACH SITE USE ONLY: COMPLETE IF ASSISTING WITH THE APPLICATION PROCESS**

I certify that I have completely explained the information on this page to the applicant. **If I determined any individual presumptively eligible, I certify that I have been trained by the DHHS to make this determination; that the individual is eligible based on the information provided to me; and that I have recorded the eligibility begin date(s) in the designated areas of the application.** The Provider Number below certifies that my agency has been authorized to assist with the application process.

| Signature of Outreach Staff Member | Agency | Provider Number | Date |
|---|---|---|---|
| | | | |